United Healthcare | Dental Benefit Providers®

Provider packet request form

Please complete all fields and email the completed form to the email address* that applies to your state and region. (Refer to the **Regional map** below as your guide.)

Please indicate in the email subject line - **Packet Request [State] [County].**

Dentist first name:	Dentist last name:	Associate/owner:	NPI:	Specialty:

Please check the dental network(s) that you wish to join:

■ PPO (Commercial) ■ Medicare ■ Medicaid ■ DHMO/Direct Compensation

Email:	**Contact name:**	
Practice name:	**Phone number:**	
Address:	**County:**	
City:	**State:**	**ZIP code:**
Mailing address: (if different from practice address)		
City:	**State:**	**ZIP code:**

Are the dentists above being added to an existing participating location? ■ Yes ■ No

Is this a new practice location? ■ Yes ■ No

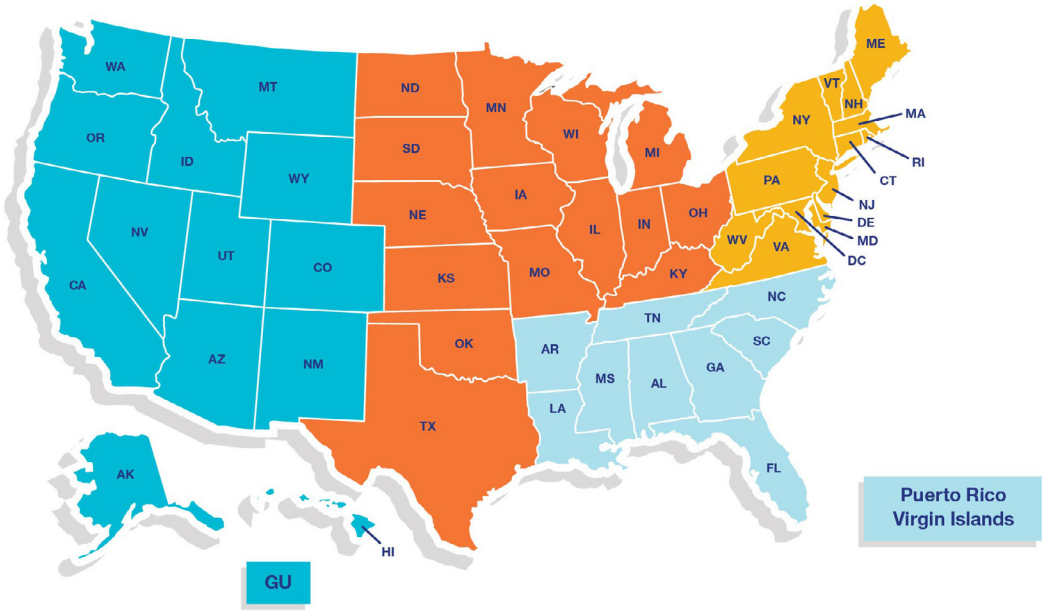
Regional map

West Region
we_packetrequest@uhc.com

Central Region
ce_packetrequest@uhc.com

Southeast Region
se_packetrequest@uhc.com

Northeast Region
ne_packetrequest@uhc.com



***Important Note:** Only requests to join our network are processed through the email addresses above. If your request does not relate to a provider joining our network or a packet request, please reach out to us at **800-822-5353** for further assistance.

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